Psychiatric Treatment Consent Form

Patient Name:

Date of Birth:

Provider Name:

Date:

Purpose

I understand that I am being offered psychiatric treatment, which may include diagnostic interviews, psychological assessments, individual or group therapy, and/or medication management. The purpose of this treatment is to support my mental health and well-being.

Confidentiality

I understand that information shared during treatment will remain confidential, except as required by law (e.g., risk to self or others, abuse reporting).

Risks and Benefits

I acknowledge that psychiatric treatment may have both risks (such as emotional discomfort, potential side effects from medication, etc.) and potential benefits (such as symptom reduction and improved functioning).

Voluntary Participation

I understand that my participation in treatment is voluntary and that I may withdraw consent and discontinue treatment at any time.

Questions

I have had the opportunity to ask questions about my treatment, and all of my questions have been answered to my satisfaction.

Consent

By signing below, I voluntarily consent to psychiatric treatment and acknowledge that I have read, understand, and agree to the terms of this consent form.

Patient Signature	Date	Provider Signature

Date